State of South Dakota

SEVENTY-FOURTH SESSION
LEGISLATIVE ASSEMBLY, 1999

346C0266

HOUSE BILL NO. 1013

Introduced by: Representatives Hunt, Duenwald, Fiegen, Hagen, Koskan, and Peterson and Senators Lawler, Brosz, Ham, and Kloucek at the request of the Interim Health and Human Services Committee

FOR AN ACT ENTITLED, An Act to establish certain requirements regarding coverage of emergency medical services in managed care plans.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:

Section 1. Terms used in this Act mean:

(1) "Covered person," a policyholder, subscriber, enrollee, or other individual participating in a managed care plan;

(2) "Emergency medical condition," the sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy;

(3) "Emergency service," health care items and services furnished or required to evaluate and treat an emergency medical condition;

(4) "Managed care contractor," a person who establishes, operates, or maintains a network of participating providers; or contracts with an insurance company, a hospital or medical service plan, an employer, an employee organization, or any other entity

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providing coverage for health care services to operate a managed care plan;

(5) "Managed care entity," a licensed insurance company, hospital or medical service plan, health maintenance organization, an employer or employee organization, or a managed care contractor that operates a managed care plan;

(6) "Managed care plan," a plan operated by a managed care entity that provides for the financing or delivery of health care services, or both, to persons enrolled in the plan through any of the following:

(a) Arrangements with selected providers to furnish health care services;

(b) Explicit standards for the selection of participating providers; or

(c) Financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the plan;

(7) "Participating provider," a provider who, under a contract with the managed care plan or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier;

(8) "Stabilized," with respect to an emergency medical condition, that no material deterioration of the condition is likely, with reasonable medical probability, to result or occur before an individual can be transferred.

Section 2. A managed care plan shall cover emergency services necessary to screen and stabilize a covered person and may not require prior authorization of such services if a prudent lay person acting reasonably would have believed that an emergency medical condition existed. With respect to care obtained from a non-contracting provider within the service area of a managed care plan, a plan shall cover emergency services necessary to screen and stabilize a covered person and may not require prior authorization of such services if a prudent layperson would have reasonably believed that use of a contracting provider would result in a delay that

would worsen the emergency, or if a provision of federal, state, or local law requires the use of a specific provider. The coverage shall be at the same benefit level as if the service or treatment had been rendered by a participating provider.

A managed care plan shall cover emergency services if the plan, acting through a participating provider or other authorized representative, has authorized the provision of emergency services.

Section 3. If a participating provider or other authorized representative of a managed care plan authorizes emergency services, the plan may not retroactively deny its authorization after the emergency services have been provided, or reduce payment for an item or service furnished in reliance on approval, unless the approval was based on a material misrepresentation about the covered person's health condition made by the provider of emergency services.

Section 4. Coverage of emergency services is subject to any contract coverage limits, applicable copayments, coinsurance, and deductibles.

Section 5. For immediately required post-evaluation or post-stabilization services, a health carrier shall provide access to an authorized representative twenty-four hours a day, seven days a week, to facilitate review, or otherwise provide coverage with no financial penalty to the covered person.

Section 6. A covered person shall have access to emergency services twenty-four hours a day, seven days a week to treat emergency medical conditions that require immediate medical attention.